Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TRINITY PARK SURGERY CENTER
3501 MATLOCK ROAD
ARLINGTON TX 76015-9936

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-4851-01

MFDR Date Received
AUGUST 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim underpaid."

Amount in Dispute: $57.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier issued reimbursement of $4329.62 under CPT 29891 and $1326.80 under CPT 29895 for a total reimbursement of $5656.42."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2011	ASC Services for CPT Code 29891-LT-SG	$57.12	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Claim processed in accordance with ambulatory surgical guidelines.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - W1-Workers compensation state fee schedule adjustment.
   - PPO reductions based on agreement with CorVel.

- This procedure on this date was previously reviewed.
- 18-Duplicate claim/service.
- Request for reconsideration reviewed. No further payment recommended.

Issues

1. Does the submitted documentation support a contractual agreement issue exists in this dispute?
2. Is the requestor entitled to reimbursement for CPT code 29891-LT-SG?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges Exceed Your Contracted/Legislated Fee Arrangement." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   CPT code 29891 is defined as "Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   According to Addendum AA, CPT code 29891 is a non-device intensive procedure.

   The City Wage Index for Arlington, Texas is 0.9474.

   The Medicare fully implemented ASC reimbursement for code 29891 CY 2011 is $1,876.83

   To determine the geographically adjusted Medicare ASC reimbursement for code 29891:

   The Medicare fully implemented ASC reimbursement rate of $1,876.83 is divided by 2 = $938.41

   This number multiplied by the City Wage Index is $938.41 X .9474 = $889.04.

   Add these two together $938.41+ $889.04 = $1,827.45.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

   $1,827.45 X 235% = $4,294.50. The respondent paid $4,316.23. As a result, additional reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor has not supported its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		06/05/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.